MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032923
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7984

FILED AUG 22 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300
Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF
1		
2	210	
3		
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DATE AMENDED

BY

BY AFFIDAVIT OF

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

77

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4649 Palm
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Sophie Middle: Last: Spears

4. DATE OF DEATH: Month: 8 Day: 14 Year: 62

5. SEX: Fem.

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH: 1-15-74

9. AGE (last birthday): 88

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): Troy Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Caleb Green

13b. MOTHER'S MAIDEN NAME: Eliza Brown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Albert Spears – 4649 Palm

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Pulmonary Edema
DUE TO (c): 434.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6-28-62 to 8-14-62 and last saw her ☒ alive on 8-14-62
Death occurred at 1:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George W. Hamilton M.D.

22b. ADDRESS: 2601 N. Whittier

22c. DATE SIGNED: 8-15-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8-17-62

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

23d. LOCATION (City, town, or county) (State): Berkley Mo.

24. FUNERAL DIRECTOR ADDRESS: A. L. Beal Und. – 4303 Delmar

25. DATE RECD. BY LOCAL REG.: AUG 16 1962

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.